**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbsga.com or by calling 1-855-397-9267.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$500** Individual/**$1,500** Family for In-Network Providers. **$1,000** Individual/**$3,000** Family for Out-of-Network Providers. In-Network Provider and Out-of-Network Provider deductibles are combined. Satisfying one helps satisfy the other. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$2,000** Individual/**$6,000** Family for In-Network Providers. **$6,000** Individual/**$18,000** Family for Out-of-Network Providers. In-Network Provider and Out-of-Network Provider out-of-pocket are separate and do not count towards each other. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Any Member Cost Shares for Pharmacy Services, Premiums, Balance-billed charges and Health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |

| | | |
|---|---|---|
| **Does this plan use a network of providers?** | Yes. See www.bcbsga.com or call 1-855-397-9267 for a list of In-Network Providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | **$25** Copay/Visit | **40%** Coinsurance | --------none-------- |
| | Specialist visit | **$35** Copay/Visit | **40%** Coinsurance | --------none-------- |
| | Other practitioner office visit | Chiropractor<br>**$15** Copay/Visit<br>Acupuncturist<br>Not Covered | Chiropractor<br>**40%** Coinsurance<br>Acupuncturist<br>Not Covered | Chiropractor<br>Coverage is limited to 20 visits per benefit year combined between In-Network and Out-of-Network Providers.<br>Acupuncturist<br>--------none-------- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Preventive care/screening/immunization | No Cost Share | **40%** Coinsurance | Well-child care, Immunizations: Deductible waived through age 5 for Out-of-Network Providers.<br>Periodic Health Examinations, Annual Gynecology Examination: Not Covered for Out-of-Network Providers. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab – Office<br>**$25** Copay/Visit<br>X-Ray – Office<br>**$25** Copay/Visit | Lab – Office<br>**40%** Coinsurance<br>X-Ray – Office<br>**40%** Coinsurance | Lab – Office<br>Costs may vary by site of service. You should refer to your formal contract of coverage for details.<br>X-Ray – Office<br>Costs may vary by site of service. You should refer to your formal contract of coverage for details. |
| | Imaging (CT/PET scans, MRIs) | **$25** Copay/Visit | **40%** Coinsurance | Costs may vary by site of service. You should refer to your formal contract of coverage for details. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbsga.com | Tier 1 - Typically Generic | **$10** Copay/Prescription for Retail Drugs **$20** Copay/Prescription for Mail Order | **40%** Coinsurance for Retail Drugs | 30-day supply for Retail Drugs. 90-day supply for Mail Order. Mail Order is Not Covered for Out-of-Network Providers. Your Coinsurance will apply after your Deductible is met. |
| | Tier 2 - Typically Preferred/Formulary Brand | **$20** Copay/Prescription for Retail Drugs **$40** Copay/Prescription for Mail Order | **40%** Coinsurance for Retail Drugs | 30-day supply for Retail Drugs. 90-day supply for Mail Order. Mail Order is Not Covered for Out-of-Network Providers. Your Coinsurance will apply after your Deductible is met. |
| | Tier 3 - Typically Non-preferred/Non-formulary Drugs | **$35** Copay/Prescription for Retail Drugs **$70** Copay/Prescription for Mail Order | **40%** Coinsurance for Retail Drugs | 30-day supply for Retail Drugs. 90-day supply for Mail Order. Mail Order is Not Covered for Out-of-Network Providers. Your Coinsurance will apply after your Deductible is met. |
| | Tier 4 -Typically Specialty Drugs | **20%** Coinsurance up to a **$200** maximum per Prescription Drug for Retail Drugs **20%** Coinsurance up to a **$200** maximum per Prescription Drug for Mail Order | **20%** Coinsurance up to a **$200** maximum per Prescription Drug for Retail Drugs **20%** Coinsurance up to a **$200** maximum per Prescription Drug for Mail Order | 30-day supply for Retail Drugs. 90-day supply for Mail Order. Specialty Drugs can only be obtained from a Specialty Pharmacy. 3,000 Prescription Drugs Out-of-Pocket maximum per member per benefit year for In-Network and Out-of-Network Retail Drugs. $3,000 Prescription Drugs Out-of-Pocket maximum per member per benefit year for In-Network and Out-of-Network Mail Order. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | **20%** Coinsurance | **40%** Coinsurance | --------none-------- |
| | Physician/surgeon fees | **0%** Coinsurance | **40%** Coinsurance | --------none-------- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | **$100** Copay/Visit | **$100** Copay/Visit | If admitted, ER Copay is waived. |
| | Emergency medical transportation | No Cost Share | No Cost Share | --------none-------- |
| | Urgent care | **$35** Copay/Visit | **$35** Copay/Visit then **40%** Coinsurance | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **20%** Coinsurance | **40%** Coinsurance | --------none-------- |
| | Physician/surgeon fee | **0%** Coinsurance | **40%** Coinsurance | --------none-------- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Mental/Behavioral Health Office Visit **$25** Copay/Visit Mental/Behavioral Health Facility Visit – Facility Charges No Cost Share | Mental/Behavioral Health Office Visit **40%** Coinsurance Mental/Behavioral Health Facility Visit – Facility Charges **40%** Coinsurance | Mental/Behavioral Health Office Visit Failure to obtain pre-authorization may result in non-coverage or reduced benefits. Mental/Behavioral Health Facility Visit – Facility Charges Failure to obtain pre-authorization may result in non-coverage or reduced benefits. |
| | Mental/Behavioral health inpatient services | **20%** Coinsurance | **40%** Coinsurance | Failure to obtain pre-authorization may result in non-coverage or reduced benefits. |
| | Substance abuse disorder outpatient services | Substance Abuse Office Visit **$25** Copay/Visit Substance Abuse Facility Visit – Facility Charges No Cost Share | Substance Abuse Office Visit **40%** Coinsurance Substance Abuse Facility Visit – Facility Charges **40%** Coinsurance | Substance Abuse Office Visit Failure to obtain pre-authorization may result in non-coverage or reduced benefits. Substance Abuse Facility Visit – Facility Charges Failure to obtain pre-authorization may result in non-coverage or reduced benefits. |
| | Substance abuse disorder inpatient services | **20%** Coinsurance | **40%** Coinsurance | Failure to obtain pre-authorization may result in non-coverage or reduced benefits. |
| **If you are pregnant** | Prenatal and postnatal care | **$100** Copay/Visit | **40%** Coinsurance | In-Network Copay applies for first office visit only. There may be other levels of cost share that are contingent on how services are provided, please see your formal contract of coverage for a complete explanation. |
| | Delivery and all inpatient services | **20%** Coinsurance | **40%** Coinsurance | Applies to inpatient facility. Other cost shares may apply depending on the services provided. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | **0%** Coinsurance | **40%** Coinsurance | Coverage is limited to 100 visits per benefit year combined between In-Network and Out-of-Network Providers. |
| | Rehabilitation services | **$35** Copay/Visit | **40%** Coinsurance | Coverage is limited to 30 visits per benefit year for Physical, Occupational Therapy combined between In-Network and Out-of-Network Providers.<br>Coverage is limited to 20 visits per benefit year for Speech Therapy combined between In-Network and Out-of-Network Providers. |
| | Habilitation services | **$35** Copay/Visit | **40%** Coinsurance | Habilitation visits count towards your Rehabilitation limit. |
| | Skilled nursing care | **0%** Coinsurance | **40%** Coinsurance | Coverage is limited to 150 days per benefit year combined between In-Network and Out-of-Network Providers. |
| | Durable medical equipment | **20%** Coinsurance | **40%** Coinsurance | --------none-------- |
| | Hospice service | No Cost Share | No Cost Share | --------none-------- |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | --------none-------- |
| | Glasses | Not Covered | Not Covered | --------none-------- |
| | Dental check-up | Not Covered | Not Covered | --------none-------- |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Most coverage provided outside the United States. See www.bcbs.com/bluecardworldwide

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-397-9267. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem BlueCross BlueShield
ATTN: Appeals
P.O. Box 105449
Atlanta, GA 30548-5449

Or Contact:

Department of Labor's Employee Benefits Security Administration at
1-866-444-EBSA (3272) or
www.dol.gov/ebsa/healthreform

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
(800) 656-2298
http://www.oci.ga.gov/ConsumerService/Home.aspx

A consumer assistance program can help you file your appeal. Contact:

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
(800) 656-2298
http://www.oci.ga.gov/ConsumerService/Home.aspx

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage**.

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides**.

## Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilnı́. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilnı́.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,590
- **Patient pays:** $1,950

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $500 |
| Copays | $410 |
| Coinsurance | $890 |
| Limits or exclusions | $150 |
| **Total** | **$1,950** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,840
- **Patient pays:** $1,560

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $500 |
| Copays | $770 |
| Coinsurance | $210 |
| Limits or exclusions | $80 |
| **Total** | **$1,560** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.